INDIVIDUAL HEALTH CLAIMS (417) SUPPLEMENTAL CLAIMANT'S STATEMENT FOR

RESIDUAL DISABILITY BENEFITS

	H-538069
	in Full (IHRISTOPHER KEARNEY Policy No. H-493629
1.	I was residually disabled from 2/8 1993 to present 19
2.	During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation
	or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 65 to the time usually required to perform these duties.
3.	I expect to return to the full performance of my occupation on
	NOTE: FOR PURPOSES OF ANSWERING QUESTIONS EO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNFARNED INCOME.
4.	My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was \$\frac{\frac
	I used the (A) \checkmark prior calendar year (B) prior twelve consecutive months earnings to determine this average.
5.	My monthly income for each month for which claim is being made is as follows:
#	Amount Month Year Amount Month Year Amount Month Year 150000 4 97
:	Any information necessary to verify the answers I have given above will be furnished upon request.
	Date 5-6 1997 Signed Christoph Kearney (Claimant)
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PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

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Case 1:02-ev-00479-MRB Document 30-10 Filed 02/16/2004 THE INSURANCE COMPANY INDIVIDUAL HEALTH CLAIMS (417) SUPPLEMENTAL CLAIMANT'S STATEMENT -Far RESIDUAL DISABILITY BENEFITS Name in Full (HKSTOPHER KEARNET Policy No. H-493629 I was residually disabled from _ 2/8 1993 to present 19 During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation_ _or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 65 of the time usually required to perform these duties. 3. I expect to return to the full performance of my occupation on not sure 19. NOTE: FOR PURPOSES OF ANSWERING QUESTIONS SO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BOMUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME. 4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was \$ 5/6 (to the nearest dollar.) I used the (A) V prior calendar year (B) prior twelve consecutive months earnings to determine this average. My monthly income for each month for which claim is being made is as follows: Month Year Amount Amount Kenth Year Amount Month Year Any information necessary to verify the answers I have given above will be furnished upon request. Date 6-2 1997 Signed Mide L. M

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

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INDIVIDUAL HEALTH CLAIMS (417) SUPPLEMENTAL CLAIMANT'S STATEMENT -

RESIDUAL DISABILITY REMEPITS

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PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

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INDIVIDUAL HEALTH CLAIMS (417) SUPPLEMENTAL CLAIMANT'S STATEMENT FOR

RESIDUAL DISABILITY BENEFITS

	H-538069
Name	in Full (11 RISTOPHER KEARNEY Policy No. H-493629
1.	I was residually disabled from _2/8 1993 to present 19
2.	During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation
-	or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 65 to the time usually required to perform these duties.
3.	I expect to return to the full performance of my occupation on
	NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.
4.	My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was \$ \frac{\fra
	I used the (A) $\stackrel{\checkmark}{\!$
5.	My monthly income for each month for which claim is being made is as follows:
\$	Amount Month Year Amount Month Year Amount Month Year /1500 6 97
:	Any information necessary to verify the answers I have given above will be furnished upon request.
	Date 7 %-12 19 97 signed Christyph L- Kearn (Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

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INDIVIDUAL HEALTH CLAIMS (417) SUPPLEMENTAL CLAIMANT'S STATEMENT FOR

RESIDUAL DISABILITY BENEFITS

H-538069
Name in Full (HRISTOPHER KENRNEY Policy No. H-493029
1. I was residually disabled from 2/8 1993 to present 19
 During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation
or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 65 of the time usually required to perform these duties.
3. I expect to return to the full performance of my occupation on
NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.
4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was \$ \frac{\mathscr{F/EC}}{\text{(to the nearest dollar.)}}\$
I used the (A) \checkmark prior calendar year (B) prior twelve consecutive months earnings to determine this average.
5. My monthly income for each month for which claim is being made is as follows:
Amount Month Year Amount Month Year Amount Month Year
Any information necessary to verify the answers I have given above will be furnished upon request.
Date 8-6 1997 Signed Chrotysh Kear
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

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INDIVIDUAL HEALTH CLAIMS (417) SUPPLEMENTAL CLAIMAT'S STATEMENT FOR

RESIDUAL DISABILITY BENEFITS

	H-538069
Namo	in Full (IHRISTOPHER KEARNEY Policy No. H-493629
1.	I was residually disabled from 2/8 1993 to present 19
2.	During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation
	or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 45 to the time usually required to perform these duties.
3.	I expect to return to the full performance of my occupation on
	NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.
4.	My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was \$ \frac{\frac{F/F_C}{F}}{C}\$ (to the nearest dollar.)
	I used the $(A) \stackrel{\checkmark}{\swarrow}$ prior calendar year (B) prior twelve consecutive months earnings to determine this average.
5.	My monthly income for each month for which claim is being made is as follows:
#	Amount Month Year Amount Month Year Amount Month Year 150000 38 97
:	Any information necessary to verify the answers I have given above will be furnished upon request.
	Date 8-26 1997 Signed Christoph Keerner

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

97 AUG 28 AN 10: 15 LIP-IHI-GENERAL

Case 1:02-cv-0047 INDIVIDUA CHRAITH OCIAINS FILE 12/16/2004 Page 13 of 29 SUPPLEMENTAL CLAIMANT'S STATEMENT

For

	RESIDURL DISRBILITY BENEFITS
Nam Pol	e in Full CHRISTOPHED L KEARNE Date of Birth 1/9-52 icy No. H 493021 + H 53806
1.	I was residually disabled from 2-8 1993 to Great 19.
2.	
	I was able to perform all of the usual daily business duties of my occupation, but only for 65 t of the time usually required to perform these duties.
3.	I expect to return to the full performate of my occupation on motoure 19
4.	I was under the care and attendance of a physician from
	NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 5 AND 6, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.
5.	My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was \$(to the nearest dollar.)
	I used the prior calendar year prior twelve consecutive months earnings to determine this average.
S .	My monthly income for each month for which claim is being made is as follows:
	Amount Month Year Amount Month Year Amount Month Year
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	Any information necessary to verify the answers I have given above will be furnished upon receipt. Date 9-15 197 Signed Churtyph Klanny
	(Claimant)
	(Street Address) (City or Town) (State)
	(Zip Code)

PLEASE ATTACH THIS FORM DIRECTLY TO THE SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

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Case 1:02-cv-00479 INREVIDUADUHEALTHO-CDAINS | (4 17)16/2004 Page 15 of 29 SUPPLEMENTAL CLAIMANT'S STATEMENT

For RESIDUAL DISABILITY BENEFITS

	RESI	DUAL	DISABILITY	BENEFITS		
lame in Full	CHRISTOPHER	L-	KEARNEY	Date of	Birth 1/-9-52	
Policy No. H	493025 + H	538	16			

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PLEASE ATTACH THIS FORM DIRECTLY TO THE SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

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Case 1:02-cv-00479 MR Tube Line 1:50-in Filed 12/16/2004 Page 17 of 29

RESIDUAL DISABILITY BENEFITS

Nam	e in Pull CHRIST OPHER KEARNEY Date of Birth 11-9-52 icy No. H 493015 + H 5780K
Pol:	ley No. <u>H 493025 + H 578</u> 06
1.	I was residually disabled from 2/8 1953 to front 19
2.	During this period of residual disability I was unable to perform the following important daily business duties of my occupation
	I was able to perform all of the usual daily business duties of my occupation, but only for 65 t of the time usually required to perform these duties.
3.	I expect to return to the full performance of my occupation on the full performance of my occupation occupation of my occupation
4.	I was under the care and attendance of a physician from $\frac{2/8}{93}$ sure 19
	NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 5 AND 6, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARMED INCOME.
5.	My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was \$ 8166 (to the nearest dollar.)
	I used the prior calendar year prior twelve consecutive months earnings to determine this average.
5.	My monthly income for each month for which claim is being made is as follows:
	Amount Month Year Amount Month Year Amount Month Year
Ч	1000 11 97
	Any information necessary to verify the answers I have given above will be furnished upon receipt.
	Date 11-29 1997 Signed Churry Kerm
	Date 11-29 1997 Signed (Musich Kerim) (Claimant)
	(Street Address) (City or Town) (State)
	(State)
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	PLEASE ATTACH THIS FORM DIRECTLY TO THE SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

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FOR RESIDUAL DISABILITY BENEFITS

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Case 1:02-cv-004 The Land Health Class 1:02-cv-004 Page 21 of 29

FOR RESIDUAL DISABILITY BENEFITS

I was under the care and attendance of a physician from 1993 NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 5 AND 6, INCLUDE MONTHLY INCOME PRON SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTH REMUNERATION, AFTER DEDUCTION OF MORNAL AND CUSTOMARY BUSINESS EXPENSES BUT REPORTE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICE PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARMED INCOME. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was \$ (to the nearest dollar.) I used the prior calendar year prior twelve consecutive months average.	Dur fol usu the	ing the	nis peri	-4 -4			T		_	
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I was under the care and attendance of a physician from 1992 19 to 19 NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 5 AND 6, INCLUDE NONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTH REMUMERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICE PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARMED INCOME. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was \$ (to the nearest dollar.) I used the prior calendar year prior twelve consecutive monther earnings to determine this average. My monthly income for each month for which claim is being made is as follows: Amount Month Year Amount Month Year Amount Month Year	T .		usually	.require	ed to peri	occupations of the	ion, bu	t only for s.	<u> 45</u>	t of
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Case 1:02-cv-0047 Case 1:02-cv

FOR RESIDUAL DISABILITY BENEFITS

in Puli CHRISTOPHER KEARNEY Date of Birth 11-9-52 cy No. H 493015 + H 53806
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During this period of residual disability I was unable to perform the following important daily business duties of my occupation
I was able to perform all of the usual daily business duties of my occupation, but only for 65 t of the time usually required to perform these duties.
I expect to return to the full performance of my occupation on motaure
I was under the care and attendance of a physician from 1993 19 to
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PLEASE ATTACH THIS FORM DIRECTLY TO THE SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

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Case 1:02-cv-00470 MERCHOCUCETTACTOR ELECTRICATION Page 25 of 29

For RESIDUAL DISABILITY BENEFITS

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Case 1:02-ev-0047 Claims Filed 12/16/2004 Page 27 of 29

RESIDUAL DISABILITY BENEFITS

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2.	During this period of residual disability I was unable to perform the following important daily business duties of my occupation
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Case 1:02-cv-00479-MRB Document 30-10 Filed 02/16/2004 Page 28 of 29

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INDIVIDUAL HEALTH CLAIMS (417) SUPPLEMENTAL CLAIMANT'S STATEMENT -

RESIDUAL DISABILITY BENEFITS

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	I used to	the (A) <u>/</u> earnings	_ prior to dete	calendar	year (B) s average	prida.	or twelve	consecu	tive
5.	My month follows:	aly inco	me for e	ach month	for which	ch claim	is being	made is	as
	Amount	Month 5		Amount	Month	Year	Amount	Month	Year
		<u> </u>	78_						
7	Any info	rmation furnishe	necessa: ed upon :	ry to ver: request.	ify the a	inswers :	I have giv	ven abov	e
	Date 6	<u>-2</u>	19_98	Signed (hust	(Clair	Keaine mant)	}	
	•								

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.